AMENDED IN SENATE JULY 5, 2001

AMENDED IN ASSEMBLY MAY 29, 2001

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AMENDED IN ASSEMBLY MARCH 28, 2001

CALIFORNIA LEGISLATURE—2001–02 REGULAR SESSION

ASSEMBLY BILL No. 1522

Introduced by Assembly Members Thomson and Frommer (Coauthors: Assembly Members Alquist, Aroner, Chan, Koretz, Negrete McLeod, Salinas, Steinberg, Wayne, and Wiggins)

February 23, 2001

~~An act to amend Sections 1373.65, 1373.95, and 1373.96 of the Health and Safety Code, and to amend Section 10133.56 of, and to add Section 10133.57 to, the Insurance Code, relating to health care coverage.~~ *An act to add Section 1373.66 to the Health and Safety Code, and to add Section 10133.57 to the Insurance Code, relating to health care.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1522, as amended, Thomson. ~~Health care providers~~ *Health care coverage: provider contracts.*

Existing law requires a health care service plan and a disability insurer to provide continuity of care coverage, as specified, by a terminated provider to an enrollee or insured who is being treated for an acute or serious chronic condition or pregnancy.

This bill would provide continuity of care, under specified conditions, to an enrollee or insured upon the failure of a provider organization, as

defined, and a health care service plan or disability insurer to renew their contract. The bill would also require a contract between a provider organization and a health care service plan or disability insurer to contain certain terms pertaining to the provision of continuing care in these circumstances. The bill would authorize the State Department of Health Services and the Division of Medical Quality of the Medical Board of California to take enforcement actions against, respectively, a licensed general acute care hospital and a physician and surgeon for failing to provide this continuity of care.

A willful violation of the provisions governing health care service plans is a crime. Because a willful violation by a health care service plan of the bill's requirements with respect to coverage would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing law requires a health care service plan to give enrollees 30 days' notice of the termination of the plan's contract with a medical group, individual practice association, or primary care provider.~~

~~This bill would require the health care service plan to give enrollees 45 days' notice of termination of the plan's contract with a medical group, individual practice association, primary care provider, specialist, hospital, or health system.~~

~~Existing law requires a health care service plan providing group coverage for new enrollees to file a written policy statement with the Department of Managed Health Care describing how its health plan facilitates continuity of care for those enrollees receiving current services from a nonparticipating provider. Existing law creates an exception from this requirement if the health care service plan includes out-of-network coverage and the enrollee is able to obtain services from his or her existing provider.~~

~~This bill would narrow the exemption by requiring that the health care service plan file continuity of care policy statements unless their health plan contract included out-of-network coverage allowing the enrollee to obtain services from the enrollee's existing provider with the same contractual terms and conditions imposed on the plan's participating providers.~~

~~Existing law requires a health care service plan and a disability insurer to provide continuity of care coverage by a terminated provider for up to 90 days if the enrollee or insured is being treated for an acute or serious chronic condition or a pregnancy, as specified. Under existing law, a plan and insurer are excused from this requirement if the terminated provider voluntarily leaves the plan or cancels the contract with the insurer, does not agree to continue to be subject to the terms and conditions of the contract, or does not accept specified rate provisions.~~

~~This bill would require a health care service plan and a disability insurer to provide continuity of care to an enrollee or insured who was receiving care from the terminated provider for any condition and would extend that period of coverage to 180 days, or until the enrollee or insured selected other coverage at his or her next open enrollment period, or until a safe transfer is made to another provider. The bill would specify, with respect to a pregnancy, that the services from a terminated provider would continue during the postpartum period or for a longer period, as specified. The bill would delete the conditions under existing law that excuse the plan or insurer from providing continuity of care coverage and would, instead, require a contract between a provider and a plan or insurer to specify reimbursement rates payable in those circumstances and to state the periods continuity of care coverage may be provided.~~

~~Existing law allows disability insurers to terminate contracts with their providers.~~

~~This bill would require a disability insurer to give insureds a 45-day written notice of the provider termination as well as instructions on selecting new providers.~~

~~A willful violation of the provisions governing health care service plans is a crime. Because a willful violation by a health care service plan of the bill's requirements with respect to extended coverage and notice of termination of providers would be a crime, this bill would impose a state-mandated local program by creating a new crime.~~

~~The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that no reimbursement is required by this act for a specified reason.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

~~SECTION 1. Section 1373.65 of the Health and Safety Code~~

SECTION 1. Section 1373.66 is added to the Health and Safety Code, to read:

1373.66. (a) Except as provided in subdivision (c), if a health care service plan and a contracting provider organization as defined in subdivision (f) fail to renew a contract prior to the expiration date of that contract, or in the case of "evergreen contracts," a provider organization has notified the plan of its intention to terminate a contract, every enrollee or subscriber of a health care service plan affected by that contract may continue to receive medical care services from the previously contracting provider organization, subject to all of the following:

(1) The enrollee must continue to be enrolled in the plan.

(2) In the case of an enrollee or subscriber under a group contract, until the anniversary date of the contract covering the enrollee or subscriber occurs, not to exceed 12 months, or an opportunity for the enrollee or subscriber to select a new plan has occurred.

(3) In the case of an enrollee or subscriber under an individual subscriber contract, until a period of 180 days has elapsed from the expiration or termination date as specified above.

(b) Every contract between a health care service plan and a contracting provider organization shall require that, in the event the contract is not renewed or has terminated, the provider shall nevertheless continue rendering professional and hospital services to the plan's enrollees and subscribers, subject to the limitations established in subdivision (a).

(c) Every contract between a health care service plan and a contracting provider organization shall contain provisions requiring continuity of care pursuant to this section. The contract shall also specify the reimbursement rate that shall be in effect for that period. Unless the contract specifies a different reimbursement rate, the rate shall be the reimbursement rate in effect immediately prior to the nonrenewal or termination of the contract, as adjusted to reflect the California Medical Inflation Index for the most recent 12-month period.

(d) The provisions of this section shall not apply in any of the following circumstances:

(1) The health care service plan does not renew a contract with a provider because the provider endangered the health and safety of the enrollee or subscriber, breached the contract between the plan and the provider, or did not meet the plan's quality of care standards.

(2) The health care service plan does not renew a contract with a provider because the provider committed criminal or fraudulent acts, or engaged in grossly unprofessional conduct.

(3) The health care service plan does not renew or terminate a contract due to reasonably demonstrable concerns regarding the financial ability of the group to provide quality medical care as required by the contract.

(4) The provider no longer maintains offices or provides services in the geographic area of the enrollee or subscriber.

(e) For contract nonrenewals or terminations between a health care service plan and an individual provider, an enrollee or subscriber may continue seeing that provider in accordance with the provisions of Section 1373.96.

(f) For purposes of this section, "contracting provider organization" means a medical group, an individual practice association, a hospital system that includes two or more acute care hospitals, or a health system that includes two or more acute care hospitals and a medical group.

(g) Notwithstanding any provision of this chapter, the Division of Medical Quality of the Medical Board of California may commence a disciplinary action against a physician and surgeon who fails to provide continuity of care as described in this section, and an appropriate penalty as described in Article 12 (commencing with Section 2220) of Chapter 5 of Division 2 of the Business and Professions Code may be imposed against the physician and surgeon.

(h) Notwithstanding any provision of this chapter, the State Department of Health Services may take enforcement action, including the imposition of fines or other penalties, against a licensed acute care hospital that fails to provide continuity of care as described in this section.

(i) Nothing in this section shall require a health care service plan to provide benefits that are not otherwise covered under the terms and conditions of the policy or plan contract.

SEC. 2. Section 10133.57 is added to the Insurance Code, to read:

10133.57. (a) Except as provided in subdivision (c), if a disability insurer and a contracting provider organization as defined in subdivision (f) fail to renew a contract prior to the expiration date of that contract, or in the case of "evergreen contracts," a provider organization has notified the insurer of its intention to terminate a contract, every insured of a disability insurer affected by that contract may continue to receive medical care services from the previously contracting provider organization, subject to all of the following:

(1) The insured must continue to be insured by the disability insurer.

(2) In the case of an insured under a group contract, until the anniversary date of the contract covering the insured occurs, not to exceed 12 months, or an opportunity for the insured to select a new plan has occurred.

(3) In the case of an insured under an individual contract, until a period of 180 days has elapsed from the expiration or termination date as specified above.

(b) Every contract between a disability insurer and a contracting provider organization shall require that, in the event the contract is not renewed or has terminated, the provider shall nevertheless continue rendering professional and hospital services to the insureds of that disability insurer, subject to the limitations established in subdivision (a).

(c) Every contract between an insurer and a contracting provider organization shall contain provisions requiring continuity of care pursuant to this section. The contract shall also specify the reimbursement rate that shall be in effect for that period. Unless the contract specifies a different reimbursement rate, the rate shall be the reimbursement rate in effect immediately prior to the nonrenewal or termination of the contract, as adjusted to reflect the California Medical Inflation Index for the most recent 12-month period.

(d) The provisions of this section shall not apply in any of the following circumstances:

(1) The insurer does not renew a contract with a provider because the provider endangered the health and safety of the

insured, breached the contract between the insurer and the provider, or did not meet the insurer's quality of care standards.

(2) The insurer does not renew a contract with a provider because the provider committed criminal or fraudulent acts, or engaged in grossly unprofessional conduct.

(3) The insurer does not renew or terminate a contract due to reasonably demonstrable concerns regarding the financial ability of the group to provide quality medical care as required by the contract.

(4) The provider no longer maintains offices or provides services in the geographic area of the insured.

(e) For contract nonrenewals or terminations between an insurer and an individual provider, an insured may continue seeing that provider in accordance with the provisions of Section 10133.56.

(f) For purposes of this section, "contracting provider organization" means a medical group, an individual practice association, a hospital system that includes two or more acute care hospitals, or a health system that includes two or more acute care hospitals and a medical group.

(g) Notwithstanding any provision of this chapter, the Division of Medical Quality of the Medical Board of California may commence a disciplinary action against a physician and surgeon who fails to provide continuity of care as described in this section, and an appropriate penalty as described in Article 12 (commencing with Section 2220) of Chapter 5 of Division 2 of the Business and Professions Code may be imposed against the physician and surgeon.

(h) Notwithstanding any provision of this chapter, the State Department of Health Services may take enforcement action, including the imposition of fines or other penalties, against a licensed acute care hospital that fails to provide continuity of care as described in this section.

(i) Nothing in this section shall require an insurer to provide benefits that are not otherwise covered under the terms and conditions of the insurer contract.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or

infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~is amended to read:~~

~~1373.65. (a) (1) Forty-five days prior to a plan terminating, for any reason, a contract with a medical group, individual practice association, specialist, primary care provider, hospital, or health system, the plan shall provide written notice of the termination to enrollees who are at that time receiving a course of treatment from a provider of that medical group, individual practice association, primary care provider, specialist, hospital, or health system or are designated as having selected that medical group, individual practice association, primary care provider, specialist, hospital, or health system for their care. The notice shall include instructions on selecting new providers and shall be jointly signed by a representative of the plan and of the medical group, individual practice association, primary care provider, specialist, hospital, or health system.~~

~~(2) If a plan, without advance notice to a primary care provider, terminates the primary care provider because of his or her endangering the health and safety of patients, committing criminal or fraudulent acts, or engaging in grossly unprofessional conduct, the notice requirement of paragraph (1) is not applicable. Instead, the plan, within 30 days of having terminated the primary care provider, shall provide written notice of the termination to the enrollees who have selected that primary care provider.~~

~~(b) When a plan terminates a contractual arrangement with an individual provider within a medical group or individual practice association, the plan may request that the medical group or individual practice association notify the enrollees who are patients of that provider of the termination.~~

~~(c) A plan shall disclose the reasons for the termination of a contract with a provider to the provider only when the termination occurs during the contract year.~~

~~(d) Notwithstanding subdivision (c), whenever a plan indicates that a provider's contract is being terminated for quality of care reasons, it shall state specifically what those reasons are.~~

~~(e) A plan that relies on primary care providers shall have a process in place to assure that patients who do not have a primary care provider have access to medical care, including specialists.~~

~~(f) If an enrollee has not been notified pursuant to subdivision (a) that his or her primary care provider has ceased to be affiliated with the enrollee's plan, the enrollee is not required to have the approval of a primary care provider to authorize a referral within the plan. All self-referrals within the plan shall be approved for a period of 60 days from the date of the termination of the enrollee's primary care provider or until a primary care provider is assigned or chosen, whichever is earlier.~~

~~This subdivision does not apply if the enrollee has direct access to a primary care provider.~~

~~A plan may not retroactively assign an enrollee to a new primary care provider to avoid financial responsibility for any enrollee self-referrals due to a failure to notify the enrollee pursuant to subdivision (a).~~

~~(g) All notifications required by this section shall be by United States mail. If the notice to the enrollee is returned as undeliverable, the plan shall make a good faith effort to notify the enrollee at the first appropriate contact with the plan.~~

~~(h) (1) For purposes of this section, "primary care provider" means a primary care physician, as defined in Section 14254 of the Welfare and Institutions Code, who provides care for the majority of an enrollee's health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.~~

~~(2) For purposes of this section, if a specialist meets the criteria of paragraph (1), he or she may be a primary care provider for an enrollee.~~

~~SEC. 2. Section 1373.95 of the Health and Safety Code is amended to read:~~

~~1373.95. (a) On or before July 1, 1996, every health care service plan that provides coverage on a group basis shall file with the Department of Managed Health Care, a written policy describing how the health plan shall facilitate the continuity of care for new enrollees receiving services during a current episode of care for an acute condition from a nonparticipating provider. This written policy shall describe the process used to facilitate the continuity of care, including the assumption of care by a~~

~~participating provider. Notice of the policy and information regarding how enrollees may request a review under the policy shall be provided to all new enrollees, except those enrollees who are not eligible as described in subdivision (e). A copy of the written policy shall be provided to eligible enrollees upon request.~~

~~(b) The written policy shall describe how requests to continue services with an existing provider are reviewed by the plan. The policy shall ensure that reasonable consideration is given to the potential clinical effect that a change of provider would have on the enrollee's treatment for the acute condition.~~

~~(c) A health care service plan may require any nonparticipating provider whose services are continued pursuant to the written policy to agree in writing to meet the same contractual terms and conditions that are imposed upon the plan's participating providers, including location within the plan's service area, reimbursement methodologies, and rates of payment. If the health care service plan determines that a patient's health care treatment should temporarily continue with the patient's existing provider, the health care service plan shall not be liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provision of services by the existing provider.~~

~~(d) Nothing in this section shall require a health care service plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.~~

~~(e) The written policy shall not apply to any enrollee who is offered an out-of-network option, or who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans.~~

~~(f) This section shall not apply to health plan contracts that include out-of-network coverage under which the enrollee is able to obtain services from the enrollee's existing provider at the same contractual terms and conditions that are imposed upon the plan's participating providers, including location within the plan's service area, reimbursement methodologies, and rates of payment.~~

~~(g) For purposes of this section, ''provider'' refers to a person who is described in subdivision (f) of Section 900 of the Business and Professions Code.~~

~~SEC. 3. Section 1373.96 of the Health and Safety Code is amended to read:~~

~~1373.96. (a) Every health care service plan shall, at the request of an enrollee, arrange for the continuation of covered services rendered by a terminated provider to an enrollee who is undergoing a course of treatment from a terminated provider at the time of the contract termination, subject to the provisions of this section.~~

~~(b) The plan shall, at the request of an enrollee, provide for continuity of care for the enrollee by a terminated provider who has been providing care to the enrollee. The plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider for a period, at the option of the enrollee, of either up to 180 days or until the enrollee has chosen a new plan during his or her next open enrollment period, or for a longer period than selected by the enrollee if necessary for a safe transfer to another provider as determined by the plan in consultation with the terminated provider, consistent with good professional practice. In the case of a pregnancy, the plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider until postpartum services related to the delivery are completed or for a longer period if necessary for a safe transfer to another provider as determined by the plan in consultation with the terminated provider, consistent with good professional practice.~~

~~(c) A contract between a health care service plan and a provider shall include a provision specifying the terms of reimbursement after the contract's termination date, if another agreement has not been reached to extend its provisions. The contract shall also contain a provision stating: ''If, upon the termination of this contract, a new agreement has not been agreed upon in writing, the provider shall continue to provide services to the plan's enrollees for one of the following periods: (1) 180 days from the contract's termination date. (2) Until the enrollee has selected a new plan during his or her next open enrollment period. (3) Until a safe transfer of the enrollee to another provider is made, as determined by the plan in consultation with the provider, consistent with good professional practice. During this period, the terms and conditions of this contract shall remain in effect and are binding, except that the agreed-upon rate for reimbursement of services provided after the contract termination date shall apply.''~~

~~(d) A description as to how an enrollee may request continuity of care pursuant to this section shall be provided in any plan evidence of coverage and disclosure form issued after July 1, 1999. A plan shall provide a written copy of this information to its contracting providers and provider groups. A plan shall also provide a copy to its enrollees upon request and whenever notice pursuant to Section 1373.65 is required.~~

~~(e) The payment of copayments, deductibles, or other cost sharing components by the enrollee during the period of continuation of care with a terminated provider shall be the same copayments, deductibles, or other cost sharing components that would be paid by the enrollee when receiving care from a provider currently contracting with or employed by the plan.~~

~~(f) If a plan delegates the responsibility of complying with this section to its contracting providers or contracting provider groups, the plan shall ensure that the requirements of this section are met.~~

~~(g) For the purposes of this section:~~

~~(1) ''Provider'' means a person who is a licentiate, as defined in Section 805 of the Business and Professions Code or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code, a provider group, or a health facility as defined in Section 1250.~~

~~(2) ''Terminated provider'' means a provider whose contract to provide services to plan enrollees is terminated or not renewed by the plan or one of the plan's contracting provider groups. A terminated provider is not a provider who voluntarily leaves the plan or contracting provider group.~~

~~(3) ''Provider group'' includes a medical group, independent practice association, or any other similar group of providers.~~

~~(h) This section shall not require a plan or provider group to provide for continuity of care by a provider whose contract with the plan or group has been terminated or not renewed for reasons relating to grossly unprofessional conduct, a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Profession Code, or fraud or other criminal activity.~~

~~(i) This section shall not require a plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.~~

~~(j) The provisions contained in this section are in addition to any other responsibilities of health care service plans to provide continuity of care pursuant to this chapter. Nothing in this section shall preclude a plan from providing continuity of care beyond the requirements of this section.~~

~~SEC. 4. Section 10133.56 of the Insurance Code is amended to read:~~

~~10133.56. (a) Disability insurers who provide hospital, medical, or surgical coverage and that negotiate and enter into contracts with professional or institutional providers to provide services at alternative rates of payment pursuant to Section 10133, shall, at the request of an insured, arrange for the continuation of covered services rendered by a terminated provider to an insured who is undergoing a course of treatment from a terminated provider at the time of the contract termination, subject to the provisions of this section.~~

~~(b) The insurer shall, at the request of an insured, provide for continuity of care for the insured by a terminated provider who has been providing care to an insured. Continuity of care shall be provided for a period, at the option of the insured, of either up to 180 days or until the insured has chosen another insurer or health care service plan during his or her next open enrollment period, or for a longer period than selected by the insured if necessary to ensure a safe transfer to another provider, as determined by the insurer, in consultation with the terminated provider, consistent with good professional practice. In the case of pregnancy, continuity of care shall be provided through the course of the pregnancy and during the postpartum period. After the required period of continuity of care has expired pursuant to this section, coverage shall be provided pursuant to the general terms and conditions of the insured's policy.~~

~~(c) A contract between an insurer and a provider shall include a provision specifying the terms for reimbursement after the contact termination date, if another agreement is not reached to extend its provisions. The contract shall also include a provision stating: "If upon the termination of this contract, a new agreement has not been agreed upon in writing, the provider shall continue to provide services to the insured for one of the following periods: (1) 180 days from the contract's termination date. (2) Until the insured has selected a different insurer or a health care service plan during~~

his or her next open enrollment period. (3) Until a safe transfer of the insured to another provider is made, as determined by the insurer in consultation with the provider, consistent with good professional practice. During this period, the terms and conditions of this contract shall remain in effect and are binding, except that the agreed-upon rate for reimbursement of services provided after the contract termination date shall apply.''

(d) Notice as to how an insured may request continuity of care pursuant to this section shall be provided in any insurer evidence of coverage and disclosure form issued after July 1, 1999. An insurer shall provide a written copy of this information to its contracting providers and provider groups. An insurer shall also provide a copy to its insureds upon request.

(e) The payment of copayments, deductibles, or other cost sharing components by the insured during the period of continuation of care with a terminated provider shall be the same copayments, deductibles, or other cost sharing components that would be paid by the insured when receiving care from a provider currently contracting with the insurer.

(f) If an insurer delegates the responsibility of complying with this section to its contracting entities, the insurer shall ensure that the requirements of this section are met.

(g) For the purposes of this section:

(1) ''Provider'' means a person who is a licentiate as defined in Section 805 of the Business and Professions Code or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code, a provider group, or a health facility as defined in Section 1250.

(2) ''Terminated provider'' means a provider whose contract to provide services to insureds is terminated or not renewed by the insurer or one of the insurer's contracting provider groups. A terminated provider is not a provider who voluntarily leaves the insurer or contracting provider group.

(3) ''Provider group'' includes a medical group, independent practice association, or any other similar group of providers.

(h) This section shall not require an insurer or provider group to provide for continuity of care by a provider whose contract with the insurer or group has been terminated or not renewed for reasons relating to grossly unprofessional conduct, a medical disciplinary cause or reason, as defined in paragraph (6) of

~~subdivision (a) of Section 805 of the Business and Professions Code, or fraud or other criminal activity.~~

~~(i) This section shall not require an insurer to cover services or provide benefits that are not otherwise covered under the terms and conditions of the insurer contract.~~

~~(j) The provisions contained in this section are in addition to any other responsibilities of insurers to provide continuity of care pursuant to this chapter. Nothing in this section shall preclude an insurer from providing continuity of care beyond the requirements of this section.~~

~~SEC. 5. Section 10133.57 is added to the Insurance Code, to read:~~

~~10133.57. (a) (1) Disability insurers who provide hospital, medical, or surgical coverage and that negotiate and enter into contracts with professional or institutional providers to provide services at alternative rates of payment pursuant to Section 10133, shall, 45 days prior to terminating, for any reason, a contract with a medical group, individual practice association, primary care provider, specialist, hospital, or health system, provide written notice of the termination to insureds who are at that time receiving a course of treatment from a provider of that medical group, individual practice association, primary care provider, specialist, hospital, or health system or are designated as having selected that medical group, individual practice association, primary care provider, specialist, hospital or health system for their care. The notice shall include instructions on selecting new providers and shall be jointly signed by a representative of the insurer and of the medical group, individual practice association, primary care provider, specialist, hospital, or health system.~~

~~(2) If an insurer, without advance notice to a primary care provider, terminates the primary care provider because of his or her endangering the health and safety of patients, committing criminal or fraudulent acts, or engaging in grossly unprofessional conduct, the notice requirement of paragraph (1) is not applicable. Instead, the insurer, within 30 days of having terminated the primary care provider, shall provide written notice of the termination to the insureds who have selected that primary care provider.~~

~~(b) When an insurer terminates a contractual arrangement with an individual provider within a medical group or individual~~

~~practice association, the insurer may request that the medical group or individual practice association notify the insureds who are patients of that provider of the termination.~~

~~(c) An insurer shall disclose the reasons for the termination of a contract with a provider to the provider only when the termination occurs during the contract year.~~

~~(d) Notwithstanding subdivision (c), whenever an insurer indicates that a provider's contract is being terminated for quality of care reasons, it shall state specifically what those reasons are.~~

~~(e) An insurer that relies on primary care providers shall have a process in place to assure that patients who do not have a primary care provider have access to medical care, including specialists.~~

~~(f) If an insured has not been notified pursuant to subdivision (a) that his or her primary care provider has ceased to be affiliated with the insurer, the insured is not required to have the approval of a primary care provider to authorize a referral to another provider.~~

~~An insurer may not retroactively assign an insured to a new primary care provider to avoid financial responsibility for any self-referrals due to the insurer's failure to notify the insured pursuant to subdivision (a).~~

~~(g) All notifications required by this section shall be by United States mail. If the notice to the insured is returned as undeliverable, the insurer shall make a good faith effort to notify the insured at the first appropriate contact with the insurer.~~

~~(h) (1) For purposes of this section, ''primary care provider'' means a primary care physician, as defined in Section 14254 of the Welfare and Institutions Code, who provides care for the majority of an insured's health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.~~

~~(2) For purposes of this section, if a specialist meets the criteria of paragraph (1), he or she may be a primary care provider for an insured.~~

~~SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of~~

~~the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.~~

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